Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

BC5735

Name_____ Date of Birth____ / ____ / ____ Age _____

Preferred method of contact: (circle one)

Home_____ Cell_____ May we leave a message? ☐ Yes ☐ No

May we leave a message with anyone else? ☐ Yes ☐ No If YES, please specify:_____

1) Is it possibile you are pregnant? ☐ Yes ☐ No

2) When was the date of last menstrual period?____ / ____ / ____

Age at 1st period: _____ Have you gone through menopause? ☐ Yes ☐ No Age at menopause:_____

3) Number of pregnancies:_____ Age at 1st live birth:_____

4) Are you currently breast feeding? ☐ Yes ☐ No

5) Have you had a previous mammogram? ☐ Yes ☐ No

If YES, when?_____ Where?_____

6) When did your doctor last examine your breasts?

Within the past year____ Not within the past year____ I do not remember_____

7) Reason for today's visit:

Yearly screening_____ Short term follow-up (<9 months from prior) _____ New problem_____

8) ***If you are currently having SPECIFIC PROBLEMS with your breasts, please check all that apply and for how long.***

	Right	Date	Left	Date	
Lump	_____	_____	_____	_____	Size:_____
Nipple Discharge	_____	_____	_____	_____	Color:_____
Other	_____				

9) Have you had previous BREAST SURGERY or BIOPSY? ☐ Yes ☐ No

If YES, check all that apply and provide dates:

	Right	Date	Left	Date
Cancer (lumpectomy)	_____	_____	_____	_____
Cancer (mastectomy)	_____	_____	_____	_____
Benign surgery	_____	_____	_____	_____
Benign Ultrasound Needle Biopsy	_____	_____	_____	_____
Benign Stereotactic Biopsy	_____	_____	_____	_____
Benign MRI Biopsy	_____	_____	_____	_____
Benign Cyst Aspiration	_____	_____	_____	_____
Breast Reduction	_____	_____	_____	_____
Breast Implants	_____	_____	_____	_____

Type: Saline _____ Silicone_____ Implant Rupture ☐ Yes ☐ No

If you had breast cancer surgery, did you also receive: Chemotherapy____ Radiation____ Tamoxifen____ Other____

10) Have you tested POSITIVE for a breast cancer gene? ☐ Yes ☐ No

If YES, check all that apply: BRCA1_____ BRCA2_____ ATM_____ CHEK2_____ Other_____

11) Have any family members had breast cancer? ☐ Yes ☐ No

If YES, check all that apply and age at diagnosis:

Mother	_____ Age_____	Father	_____ Age_____	Aunt	_____ Age_____
Grandmother	_____ Age_____	Brother	_____ Age_____	Other	_____ Age_____
Daughter	_____ Age_____	Sister	_____ Age_____		

12) Have you or a family member had any type of cancer ***other*** than breast? ☐ Yes ☐ No

If YES, please specify:_____

In order to ensure the most accurate reading of today's scan, I hereby authorize the release of medical information including radiology reports, films and/or CDs, to the Northwell Imaging Center. I understand if that if thare is a charge far the copying of this information that I am solely responsible for said charge.

Patient Signature:_____ Date:_____ Time:_____

BREAST HISTORY FORM